



Advance Appropriations for Veterans' Health Care: Issues and Options for Congress

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April 28, 2009

Congressional Research Service

7-5700

www.crs.gov

R40489

Report Documentation Page				Form Approved OMB No. 0704-0188	
Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.					
1. REPORT DATE 28 APR 2009		2. REPORT TYPE		3. DATES COVERED 00-00-2009 to 00-00-2009	
4. TITLE AND SUBTITLE Advance Appropriations for Veteran's Health Care: Issues and Options for Congress				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S)				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Congressional Research Service, Library of Congress, 101 Independence Ave., SE, Washington, DC, 20540-7500				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT Same as Report (SAR)	18. NUMBER OF PAGES 20	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

Summary

The Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA) operates the Nation's largest health care delivery system, with about 222,000 employees supporting its mission. It is also the largest provider of health care education and training for medical residents and other health care trainees in the United States. In FY2008, VHA provided medical care to approximately 5.6 million unique patients and spent approximately \$43.5 billion for medical care and research.

A coalition of veterans' service organizations (VSOs) has been calling on Congress to provide VHA with a budget which is "sufficient, timely, and predictable." These organizations have asserted that VHA has underestimated its budget in the past. Moreover, VSOs contend that Congress has not enacted the VA budget by the beginning of the fiscal year. According to these organizations the delays in the enactment of the budget have exacerbated operational challenges—such as, differing capital expenditures, delaying recruitment, restricting acquisitions, limiting maintenance—faced by VHA network directors. To mitigate these issues VSO's have proposed that Congress change the funding process for VHA to an advance appropriation.

In general, an appropriations act makes budget authority available beginning on October 1 of the fiscal year (FY) for which the appropriations act is passed ("budget year"). However, there are some types of appropriations that don't follow this pattern; among them are advance appropriations. An advance appropriation means appropriation of new budget authority that becomes available one or more fiscal years beyond the fiscal year for which the appropriations act was passed (that is, beyond the budget year). Under the current scoring guidelines (estimating the budgetary effects of pending legislation and comparing them to the budget resolution or to any limits that may be set in law), new budget authority for an advance appropriation is scored in the fiscal year in which the funds become available for obligation.

In the 111th Congress, the Veterans Health Care Budget Reform and Transparency Act of 2009 (H.R. 1016 and a companion version S. 423) has been introduced. Under H.R. 1016 and S. 423, the following accounts that fund VHA—medical services, medical support and compliance, and medical facilities—would be funded as an advance appropriation beginning with FY2011. The funding would be under a discretionary budget authority, and the legislation calls for a study by the Comptroller General (of the Government Accountability Office) on the adequacy and accuracy of the budget projections based on VHA's Enrollee Health Care Projection Model (EHCPM).

There are two broad sets of issues related to advance funding for some accounts of VHA: budget enforcement issues and implementation issues. Among budget enforcement issues a key issue is that an advance appropriation mechanism may not be able to insulate a program from budget enforcement and competition with other programs. Among implementation issues a key issue is that funding VHA under an advance appropriation, based on the EHCPM, could create budget shortfalls if there are unanticipated developments affecting the EHCPM.

This report will be updated as events warrant.

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Introduction

The Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA) operates the Nation's largest health care delivery system with about 222,000 employees supporting its mission.¹ It is also the largest provider of health care education and training for medical residents and other health care trainees in the United States.² In FY2008, VHA provided medical care to approximately 5.6 million unique patients and spent approximately \$43.5 billion for medical care and research.³

A coalition of veterans' service organizations (VSOs) has been calling on Congress to provide VHA with a budget which is "sufficient, timely, and predictable."⁴ They have asserted that VHA has underestimated its budget in the past. For instance, according to the Government Accountability Office (GAO), due to "unrealistic assumptions about the impact of some of [VHA's] policies, inaccurate calculations, and insufficient data for useful budget projections,"⁵ in June 2005 the George W. Bush Administration submitted a \$975 million supplemental VHA appropriations request to Congress, and in July of that same year the President submitted an additional \$1.977 billion supplemental VHA appropriations request to Congress.⁶ Congress has generally not enacted the VA budget by the beginning of the fiscal year. In most of the past 20 years (FY1989 to FY2009) VA received its annual appropriation prior to the beginning of the fiscal year only on four occasions—in FY1989, FY1995, FY1997, and FY2009 (see the **Appendix**).⁷ According to VSOs, these delays in the enactment of the budget have exacerbated operational challenges—such as delaying capital expenditures, delaying recruitment, restricting acquisitions, limiting maintenance—faced by VHA network directors. Moreover, former VHA officials have testified about operational difficulties they faced during their tenures due to the uncertainty of funding.⁸ To mitigate these issues, VSO's have proposed that Congress change the funding process for VHA to an advance appropriation.

This report discusses issues regarding authorization of an advanced appropriation for certain medical care accounts of VHA. To provide some context to the discussion of these issues, the first section of this report provides background on funding categories for federal programs as well as how they relate to the federal budget. It also reiterates the reasons that have been put forth by VSOs as a rationale to fund VHA under an advance appropriation, and the accounts that would be affected by an advance appropriation proposal. Lastly this section describes the approach used by

¹ Department of Veterans Affairs, Office of Management, *FY2008 Performance and Accountability Report*, Washington, DC, November 2008, p. 16.

² Ibid, p.10.

³ Ibid, p16.

⁴ The Partnership for Veterans Health Care Budget Reform, *Reforming Veterans Health Care Funding*, Issue Brief, Washington, DC, March 2009.

⁵ Testimony of Randy Williamson in U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, *Veterans Affairs Department Challenges*, 111th Cong., 1st sess., March 12, 2009.

⁶ For details on the budget shortfall see CRS Report RL32975, *Veterans' Medical Care: FY2006 Appropriations*, by Sidath Viranga Panangala.

⁷ It should be noted that during this time period most other federal agencies received its budget well into the new fiscal year.

⁸ U.S. Congress, Senate Committee on Veterans' Affairs, *Hearing on VA Health Care Funding Issues*, 110th Cong., 1st sess., July 25, 2007, S. Hrg. 110-215 (Washington: GPO, 2007), p.79.

VHA to construct the budget estimates that are critical to the determination of the funding level under an advance appropriation.

The second section of this report discusses the definition of an advance appropriation and provides examples of federal programs that are currently funded under an advance appropriation or have been in the past. The third section outlines the two broad issues that Congress confronts in considering proposal to establish and implement an advance appropriation: (1) authorization issues, and (2) implementation issues.

This report concludes with a section that provides some options Congress may opt to consider either independently or in conjunction with an advance appropriation proposal.

Overview of Spending Categories in the Federal Budget and Associated Enforcement Procedures⁹

To provide some context on funding VA health care programs under an advance appropriation it is essential to understand the funding categories for federal programs, and how they relate to the federal budget. One of the most basic characterizations of federal spending involves two separate categories, discretionary spending and direct spending. Discretionary spending is provided in, and controlled by, annual appropriations acts under the jurisdiction of the House and Senate Appropriations Committees. Direct spending, also referred to as mandatory spending, is controlled by substantive legislation under the jurisdiction of the various House and Senate legislative committees.

In most instances, the substantive law that creates direct spending also includes the financing mechanism for it, often a “permanent appropriation” that provides funds automatically each year without the need for any further legislative action (e.g., Social Security and Medicare), or that provides funds automatically each year over a fixed, multi-year period (e.g., the periodic farm bill and highway bill). In some cases, a direct spending program does not have its own financing mechanism and requires financing through an annual appropriations act (e.g., veterans compensation and pensions); in these cases, however, the level of direct spending effectively is controlled in the substantive legislation, not the annual appropriations act.

The annual budget resolution establishes a framework for the consideration of all legislation with a budgetary impact, including annual appropriations acts (regular, supplemental, and continuing) and direct spending measures, as well as revenue and debt-related measures.

Different enforcement procedures are used with respect to annual appropriations acts and direct spending measures. The key enforcement tool applicable to the former is the “Section 302(b)” spending allocations, named after the pertinent section of the Congressional Budget Act of 1974, and the point of order that may be raised against measures that violate the allocations. Under this tool, the Appropriations Committee in each chamber divides its allocation of total discretionary spending for the fiscal year made under the budget resolution among its 12 subcommittees; the cost of each appropriations act then is compared to the Section 302(b) spending allocation

⁹ This section was written with the assistance of Robert Keith, Specialist in American National Government.

assigned to the pertinent subcommittee to determine if the act adheres to the spending levels under the budget resolution.

Other enforcement tools apply to the consideration of direct spending measures, including “Section 302(a)” allocations of total direct spending to committees (unlike the Appropriations Committees, the legislative committees do not subdivide their total allocations by subcommittee), the optional budget reconciliation process, and House and Senate “pay-as-you-go” (PAYGO) rules, among others.

Funding for the Department of Veterans Affairs entails both discretionary spending and direct spending. In FY2008, for example, the Department’s total spending of approximately \$88 billion consisted of about \$43 billion in discretionary spending and \$44 billion in direct spending. Most of the Department’s discretionary spending involves medical care while most direct spending involves compensation and benefits.¹⁰

Mandatory Funding for VA Health Care

For more than a decade VSOs have been repeatedly calling for “assured funding” or “guaranteed” or “mandatory” funding for VA health care. Although each of these terms has a different definition, in general, the VSO community has proposed moving funding for VA health care from a discretionary appropriation to a mandatory appropriation. VSOs claim that both the sufficiency of funding for veterans’ health care as well as the timeliness and predictability of such funding would be addressed by funding VA health care under a mandatory appropriation.¹¹ The *Independent Budget*¹² has stated that:

For almost two decades, the dysfunctional budget and appropriations process for veterans’ health care has prevented VA officials from efficiently managing and planning for the future of veterans’ health-care programs and services. Not knowing when or what level of funding it will receive from year to year—or whether Congress will approve or oppose Administration policy proposals directly affecting the budget—severely impairs VA’s ability to recruit and retain staff, contract for services, procure equipment and supplies, and perform planning and administrative functions.¹³

Although legislation was introduced in previous Congresses to provide funding for VA health care under a mandatory appropriation, such proposals did not win widespread support among the authorization or appropriations committees. Also pay-as-you-go (PAYGO) budget rules adopted by Congress required offsets for any new direct spending program (see previous section on

¹⁰ See CRS Report RL34598, *Veterans Medical Care: FY2009 Appropriations*, by Sidath Viranga Panangala, and CRS Report RL34558, *Military Construction, Veterans Affairs, and Related Agencies: FY2009 Appropriations*, by Daniel H. Else, Christine Scott, and Sidath Viranga Panangala.

¹¹ U.S. Congress, House Committee on Veterans’ Affairs, *Funding the U.S. Department of Veterans Affairs of the Future*, 110th Cong., 1st sess., October 3, 2007 (Washington: GPO, 2008), p. 47.

¹² Four veteran’s service organizations collectively author *The Independent Budget* (IB) each year. The four organizations are: the AMVETS, Disabled American Veterans (DAV); Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars of the United States (VFW).

¹³ AMVETS, Disabled American Veterans, Paralyzed Veterans of America, Veterans of Foreign Wars, *Independent Budget, Fiscal Year 2009*, p.45, [<http://es3.pva.org/independentbudget/index.htm>].

spending categories in the federal budget and enforcement procedures).¹⁴ Furthermore, some budget analysts had pointed out that a switch to a mandatory appropriation would:

- create incentives for undue expansion of the VHA;
- not be consistent with the longer term objectives of reforming the overall health care system; and
- boost federal spending at a time when other increases in federal healthcare spending would yield greater benefits.¹⁵

The analysts have also pointed out that converting VHA into a mandatory appropriation “would not entirely insulate it from budgetary pressures. Congress could cut the per-person funding amount or exclude certain groups of veterans from the formula used for computing annual funding.”¹⁶ During the 110th Congress both the House and Senate Veterans’ Affairs Committees held hearings to examine such proposals and heard from witnesses who testified for and against mandatory funding proposals for VA health care.¹⁷

Since mandatory funding proposals were not finding enough momentum to move forward, VSOs put forth a proposal in 2008 to provide advance appropriations for VA health care.¹⁸ In the 111th Congress, the Veterans Health Care Budget Reform and Transparency Act of 2009 (H.R. 1016 and a companion version S. 423) has been introduced. Under H.R. 1016 and S. 423, the following accounts that fund VHA—medical services, medical support and compliance, and medical facilities (see description of these accounts below)—would be funded as an advance appropriation beginning with FY2011. The funding would be under a discretionary budget authority, and the legislation calls for a study by the Comptroller General (that is, the Government Accountability Office) on the adequacy and accuracy of the budget projections based on VHA’s Enrollee Health Care Projection Model (see a discussion of the model below). While CRS does not take a position on the legislation, the succeeding sections discuss some possible issues concerning such a proposal, and offer options Congress may consider concerning the VHA funding process.

Currently, How Is VA Health Care Funded?

Prior to discussing the proposal for advance appropriations, it is essential to discuss the current appropriations process for VA health care programs. The VHA is funded through multiple appropriations accounts that are supplemented by other sources of revenue. Although the

¹⁴ For detailed discussions of PAYGO rules in the House and Senate see the following reports: CRS Report RL34300, *Pay-As-You-Go Procedures for Budget Enforcement*, by Robert Keith; CRS Report RL31943, *Budget Enforcement Procedures: Senate Pay-As-You-Go (PAYGO) Rule*, by Bill Heniff Jr.; and CRS Report RL33850, *The House’s “Pay-As-You-Go” (PAYGO) Rule in the 110th Congress: A Brief Overview*, by Robert Keith.

¹⁵ U.S. Congress, House Committee on Veterans’ Affairs, *Funding the U.S. Department of Veterans Affairs of the Future*, 110th Cong., 1st sess., October 3, 2007 (Washington: GPO, 2008), p.56.

¹⁶ Ibid.

¹⁷ For a complete record of these hearings see U.S. Congress, House Committee on Veterans’ Affairs, *Funding the U.S. Department of Veterans Affairs of the Future*, 110th Cong., 1st sess., October 3, 2007 (Washington: GPO, 2008), and U.S. Congress, Senate Committee on Veterans’ Affairs, *Hearing on VA Health Care Funding Issues*, 110th Cong., 1st sess., July 25, 2007, S. Hrg. 110-215 (Washington: GPO, 2007).

¹⁸ For details see [<http://www.fundingforvets.org/index.html>].

appropriations account structure has been subject to change from year to year, the appropriation accounts used to support the VHA traditionally include medical care, medical and prosthetic research, and medical administration. In addition, Congress also appropriates funds for construction of medical facilities through a larger appropriations account for construction for all VA facilities. In FY2004, “to provide better oversight and [to] receive a more accurate accounting of funds,” Congress changed the VHA’s appropriations structure.¹⁹ The Department of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act, 2004 (P.L. 108-199, H.Rept. 108-401), funded VHA through four accounts: (1) medical services, (2) medical administration, (3) medical facilities, and (4) medical and prosthetic research. In FY2009, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (P.L. 110-329) renamed the medical administration account as the medical support and compliance account. To understand some of the implications of advanced appropriations discussed later in this report it is important to understand what each of these accounts currently fund.

Medical Services

The medical services account covers expenses for furnishing inpatient and outpatient care and treatment of veterans and certain dependents, including care and treatment in non-VA facilities; outpatient care on a fee basis; medical supplies and equipment; salaries and expenses of employees hired under Title 38, United States Code; and aid to state veterans homes. In addition to the direct appropriation to this account, funds deposited in the medical care collection fund (MCCF) may be transferred to this account to remain available until expended.²⁰ In its FY2008 budget request to Congress, the VA requested the transfer of food service operations costs from the medical facilities appropriations to the medical services appropriations, and the House and Senate Appropriations Committees concurred with this request.

Medical Support and Compliance (Previously Known as Medical Administration)

The medical support and compliance account provides funds for the expenses in the administration of hospitals, nursing homes, and domiciliaries, billing and coding activities, public health and environmental hazard program, quality and performance management, medical inspection, human research oversight, training programs and continuing education, security, volunteer operations, and human resources.

¹⁹ U.S. Congress, Conference Committees, *Consolidated Appropriations Act, 2004*, conference report to accompany H.R. 2673, 108th Cong., 1st sess., H.Rept. 108-401, p. 1036.

²⁰ The Veterans' Health Care, Training, and Small Business Loan Act of 1981 (P.L. 97-72) authorized VHA to recover reasonable costs, for care provided to veterans for nonservice-connected conditions, from a state, employer, employer's insurance carrier, or automobile accident reparations insurance carrier, as appropriate. The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), enacted into law in 1986, amended P.L. 97-72, and gave the VHA the authority to bill some veterans and most health-care insurers for nonservice-connected care provided to veterans enrolled in the VA health-care system, to help defray the cost of delivering medical services to veterans. The Balanced Budget Act of 1997 (P.L. 105-33) gave the VHA the authority to retain these funds in the Medical Care Collections Fund (MCCF). Instead of returning the funds to the Treasury, the VA can use them for medical services for veterans without fiscal year limitations. For further information on MCCF see CRS Report RL34598, *Veterans Medical Care: FY2009 Appropriations*, by Sidath Viranga Panangala.

Medical Facilities

The medical facilities account covers, among other things, expenses for the maintenance and operation of VHA facilities (including non-recurring maintenance projects²¹); administrative expenses related to planning, design, project management, real property acquisition and deposition, construction, and renovation of any VHA facility; leases of facilities; and laundry services.

Medical and Prosthetic Research

This account provides funding for VA researchers to investigate a broad array of veteran-centric health topics, such as treatment of mental health conditions; rehabilitation of veterans with limb loss, traumatic brain injury, and spinal cord injury; organ transplantation; and the organization of the health care delivery system. VA researchers receive funding not only through this account but also from the Department of Defense (DOD), the National Institutes of Health (NIH), and private sources.

Budget Formulation

Historically, the major determinant of VHA's budget size and character was the number of operating beds—which was controlled by Congress.²² The preliminary budget estimate, to a large extent, was based on the funding and activity of the previous year. VHA developed system-wide workload estimates, by type of care, by forecasts submitted by field stations. Unit costs were derived from the field stations' reports of the estimated distribution of expenses by type of care. Costs associated with new programs were estimated by VA central office and added to the budget estimate.²³ The costs associated with staffing improvements, pay increases and inflation were also added to this estimate. Therefore, it could be stated that the principal assumption at each phase of the budget formulation process was that the preceding year's budget was the starting point.²⁴

In 1996, Congress enacted the Departments of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act of 1997 (P.L. 104-204). This Act required VHA to develop a plan for the allocation of health care resources to ensure that veterans eligible for medical care who have similar economic status and eligibility priority have similar access to such care, regardless of where they reside.²⁵ The plan was to “account for forecasts in expected workload and to ensure fairness to facilities that provide cost-efficient health care.”²⁶

²¹ Non-recurring maintenance projects involve the purchase of and/or improvements to buildings, land, and other structures (including equipment), where additions, alterations, and modifications are made. Non-recurring maintenance projects result in a change in space function and/or a renovation of existing infrastructure. Examples of non-recurring maintenance projects include modifying buildings to install equipment, roof replacements, clinical space renovations, and non-structural improvements to land such as landscaping.

²² U.S. Congress, House Committee on Veterans' Affairs, *Health Care for American Veterans*, prepared by National Academy of Sciences, National Research Council, 95th Cong., 1st sess., June 7, 1977, House Committee Print No.36 (Washington: GPO, 1977), p. 37.

²³ Ibid, p.42.

²⁴ Ibid.

²⁵ Department of Veterans Affairs, Office of Inspector General, *Report of Audit Congressional Concerns over Veterans Health Administration's Budget Execution*, Report No. 06-01414-160, Washington, DC, June 30, 2006, p. 2.

²⁶ Ibid.

In response to the above-mentioned Congressional mandate, as well as the mandate in the Health Care Eligibility Reform Act of 1996 (P.L. 104-262) that required the VHA to establish a priority-based enrollment system, VHA established the Enrollee Health Care Demand Model in 1998. This model has evolved over time. The VHA's Enrollee Health Care Demand Model develops estimates of future veteran enrollment, enrollees' expected utilization of health care services, and the costs associated with that utilization. These 20-year projections are by fiscal year, enrollment priority, age, Veterans Integrated Service Networks (VISN), market, and facility. The VHA budget is formulated using the model projections.

Each year, through the annual appropriations process, Congress appropriates funds to the accounts that comprise VHA. VHA's budget request to Congress begins with the formulations of the budget based on the Enrollee Health Care Projection Model (EHCPM) to estimate the demand for medical services among veterans in future years (a brief discussion of EHCPM is provided below). These estimates are then used to develop a budget request that is then included with the total VA budget request to Congress.²⁷

What Is the Enrollee Health Care Projection Model (EHCPM)?²⁸

To recognize the implications of funding some VHA accounts under an advance appropriation (AA), it is important to understand the current VHA EHCPM and how it is used to develop VHA's health care budget. While a complete description is beyond the scope of this report, this section provides a brief overview of the model. As described previously, VHA uses the EHCPM to forecast future resource requirements. The EHCPM model projects total expenditures for health care services in any given year by combining output from three model subcomponents: the enrollment projection model, the utilization projection model, and the unit cost projection model (A description of the EHCPM's three sub-models is given below). Outputs from these sub-models are then multiplied together for each of the 58 medical services (which include such services as inpatient medical, surgical, and psychiatric care; ambulatory care; pharmacy, including over the counter medications) for roughly 40,000 enrollee types. The enrollee types are defined by age category, by whether they were enrolled before or after eligibility reforms, by priority level, and by geographic sector.²⁹ EHCPM applies four types of trend factors to account for general changes in medical costs and the anticipated changes in the efficiency of VA providers. The trend factors are utilization, inflation, intensity of service provision, and a measure of management efficiency. Moreover, the model accounts for anticipated changes in veteran morbidity and reliance on the VA health care delivery system, enrollment levels, and enrollment mix. Currently the modeled expenditures comprise approximately 84% of VHA's health care budget.³⁰

²⁷ For details on the congressional budget process see, CRS Report RS20095, *The Congressional Budget Process: A Brief Overview*, by James V. Saturno; for details on the FY2009 appropriations for VHA see CRS Report RL34598, *Veterans Medical Care: FY2009 Appropriations*, by Sidath Viranga Panangala.

²⁸ Major portions of this section were drawn from the following report: Katherine M. Harris, James P. Galasso, and Christine Eibner, *Review and Evaluation of the VA Enrollee Health Care Projection Model*, The RAND Corporation, Center for Military Health Policy Research, 2008, pp. 23-43.

²⁹ The Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262) directed the VA to establish an enrollment system to keep track of veterans who plan to use VA health care. In general, a veteran must enroll in the VA health care system to be eligible for care (enrollment is free of charge). Veterans apply for enrollment by completing an Application for Health Benefits, which may be submitted in person, or by mail to a health care facility. Applications may also be submitted online.

³⁰ Department of Veterans Affairs, Veterans Health Administration, Office of the Assistant Deputy Under Secretary (continued...)

Enrollment Projection Model (EPM)

The EPM is the least complex of the three sub-models. It develops projections by applying historic veteran enrollment rates to the forecast veteran population derived from U.S. Census data. Modeled enrollment rates are obtained by age, priority level, geographic sector, and participation in Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) (OEF and OIF veterans are identified in the model as “special conflict status” veterans). The projected enrollee population is equal to current enrollment plus new enrollment minus deaths. Although enrollment rates reflect demographic trends in the veteran population, such as shifts in priority level and geographic migration, they do not account for trends in the generosity, availability, and affordability of private-sector health insurance that could lead veterans to enter or leave the VA health care system.

Utilization Projection Model (UPM)

The UPM is based on the Milliman Health Cost Guidelines (HCGs), a proprietary set of utilization-rate benchmarks derived from commercial data.³¹ The HCGs contain data on utilization for 37 of the 58 EHCPM health service categories. Milliman applies a complex set of adjustments to the HCG data to reflect the health status of VA enrollees, their reliance on VA, and the relative efficiency of VA facilities. Each year, utilization rates are adjusted to account for national trends in health care utilization and VA-specific trends in management efficiency. Since model management trends are calibrated against the local community in which each VA facility operates, projected changes over time in the efficiency of VA practice are implicitly tied to community practices. In a final step, adjusted HCG benchmarks are calibrated to actual VA workload in the model base year to account for differences between the VA and the private sector that are not captured by adjustment. Services without commercial counterparts (such as VA-specific outpatient mental health services, blind rehabilitation, and over-the-counter drugs and supplies) are projected directly from historical VA workload data.

Unit Cost Projection Model (UCPM)

The average unit cost (that is, the cost of a particular medical service) is derived through the UCPM. This is done by allocating VA's base year budget obligation to base year VA workload in each service category. Many of the service categories in the UCPM are developed at a more detailed level than the service categories defined in the VA's cost accounting system. In these cases, the model relies on calculated relationships between VA cost levels and Medicare-allowable or billed charges to estimate VA unit costs by service category. Inflation and intensity trends are then multiplied by base year average unit costs to project unit costs in any given year.

(...continued)

for Health, for Policy and Planning, *VA Enrollee Health Care Projection Model*, Presentation, October 2008.

³¹ Milliman HCGs are a pricing and utilization benchmarking tool. They are based on standard medical benefits packages for a wide range of demographic characteristics and geographic areas. Milliman, Inc. currently holds the contract to develop and maintain the EHCPM.

What Is an Advance Appropriation (AA), and How Does It Work?

Usually, an appropriations act makes budget authority available beginning on October 1 of the fiscal year (FY) for which the appropriations act is passed (“budget year”). However, there are three types of appropriations that don’t follow this pattern. They are: advance appropriations, advance funding and forward funding. These terms are defined below.

An *advance appropriation* means appropriation of new budget authority that becomes available one or more fiscal years beyond the fiscal year for which the appropriations act was passed (that is beyond the budget year). For example, if the following language appeared in an appropriations act for FY2010, it would provide an advance appropriation for FY2011: “For medical services, \$30,854,000,000 to become available on October 1, 2010 (the start of the FY2011).” Under the current scoring guidelines, new budget authority for an advance appropriation is scored in the fiscal year in which the funds become available for obligation. In this example, you would record the budget authority in FY2011.³²

Advance funding is budget authority provided in an appropriation act to obligate and disburse (outlay) in the current FY funds from a succeeding year’s appropriation. Advance funding is a means to avoid making supplemental requests late in the fiscal year for certain entitlement programs in cases where the appropriations for the current year prove to be insufficient.

Forward funding is budget authority that is made available for obligation beginning in the last quarter of the FY for the financing of ongoing activities (usually grant programs) during the next FY. This funding is used mostly for education programs, so that obligations for grants can be made prior to the beginning of the next school year.³³

Are there other federal programs funded under an AA and why are they funded under an AA?

Several federal programs are currently funded under an AA or have been in the past.³⁴ This section provides examples of two such programs. One program is still funded under an AA, while the second is no longer funded under an AA.

The Corporation for Public Broadcasting (CPB) currently receives funding under an AA. One reason that has been cited in the literature for funding CPB under an AA is that it would “insulate public broadcasting from the year-to-year financial and political pressures which annual appropriations imposed.”³⁵ Furthermore, according to the CPB, AA allows “CPB and grant

³² For a detailed description see, CRS Report 98-721, *Introduction to the Federal Budget Process*, by Robert Keith.

³³ For further information see, CRS Report RS20441, *Advance Appropriations, Forward Funding, and Advance Funding*, by Sandy Streeter.

³⁴ A detailed list of programs funded under an AA for FY2009 is given in Executive Office of the President of the United States, Office of Management and Budget, *Appendix, Budget of the United States Government, Fiscal Year 2009*, Washington, DC, February 2008, p. 1271.

³⁵ John Witherspoon and Roselle Kovitz, “The Elusive Long-Term Money Fix,” in *History of Public Broadcasting*, ed. J.J. Yore and Richard Barbieri (Washington, DC: Current, 1987), p. 53.

recipients to include projected federal funding in their budget planning and program-acquisition processes two years before those budgets are implemented, and provides lengthy lead time for production of major programming.”³⁶

Another program funded under an AA was the Low Income Home Energy Assistance Program (LIHEAP).³⁷ In 1990 (P.L. 101-501), Congress authorized a July 1st to June 30th LIHEAP program year to allow states to plan for their heating/cooling seasons with knowledge of available funds. Therefore, in FY1993, Congress provided forward funding in the appropriations law and appropriated funds for FY1993 and an additional \$1.4 billion for the 9-month period from October 1993 through June of 1994. Subsequently in FY1994, the program was funded for the period July 1994 through June 1995.³⁸ In 1998, Congress authorized an advance appropriation for LIHEAP.³⁹ As a result, the program was taken off the program year cycle and put back on fiscal years. LIHEAP was funded under an advance appropriation only in FY1999 and FY2000.

There is no indication as to Congress’ intention in changing this program from a forward funding to an advance appropriation. It could be assumed that it was meant to continue to give states some flexibility but without the complexities associated with program vs. fiscal years. Congress hasn’t provided for an advance appropriation for LIHEAP in the appropriations laws since FY2000. Once again there is no publicly available information to provide any rationale for why Congress has not funded LIHEAP under an AA.

As seen in this example it is possible for Congress to change various funding mechanisms (from a forward funding to an advance appropriation to a regular annual appropriation) for a program from time to time. Therefore, an AA does not guarantee that VHA health care appropriations would be insulated from the unpredictability of the appropriations process.

As these examples illustrate, there are some federal programs that are currently funded under an AA. However, a majority of these programs are formula grant programs established by Congress to meet certain policy goals. These could not be equated to the largest integrated health care delivery system in the nation, and it is impossible to predict with any certainty the implications of funding certain VHA accounts under an AA.

Advance Appropriation-Related Issues for Congress

There are two broad issues related to advance funding for some accounts of VHA. The first issue is a budget enforcement issue related to current budget enforcement procedures in Congress, and the second relates to issues that may arise if such a proposal were to be implemented.

³⁶ See Corporation for Public Broadcasting, factsheet on advance appropriation at, [<http://www.cpb.org/aboutcpb/financials/appropriation/>].

³⁷ 42 U.S.C. § 8621. For further details on LIHEAP see, CRS Report RL31865, *The Low-Income Home Energy Assistance Program (LIHEAP): Program and Funding*, by Libby Perl.

³⁸ P.L. 101-501.

³⁹ P.L. 105-285.

Budget Enforcement Issue

An advance appropriation mechanism may not be able to insulate a program from budget enforcement and competition with other programs. Under the current congressional budget process, the House and Senate Budget Committees have adopted enforcement rules to maintain fiscal discipline; therefore, programs that are funded under an advanced appropriation (AA) need to be included in the yearly budget resolution. Congress may enforce the substantive provisions of the budget resolution through the use of points of order. Generally, these points of order prohibit the consideration of any legislation, or amendment that would cause a violation of the overall funding levels, the committee allocations, or the appropriations committees' subdivisions.

In general, a point of order could be raised against any AA that causes a ceiling on AA to be exceeded and that is not specified in a list of accounts appropriate for funding by AA in that budget year. For instance, in the House FY2010 Concurrent Resolution on the budget (H.Con.Res. 85), section 403 has placed limits on the amount and type of advance appropriations for FY2011 and FY2012, and listed the programs that are excepted from this budget enforcement rule.⁴⁰ In the Senate FY2010 Concurrent Budget Resolution (S.Con.Res. 13) certain accounts to be funded under an AA are included in the resolution. If these accounts are not listed a point of order could be raised, that would need a supermajority to overturn.⁴¹ H.Con.Res. 85 does not include language to exempt the medical services, medical support and compliance, and medical facilities accounts from any point of order. However, during the Senate debate of S.Con.Res. 13, Senator James Inhofe offered an amendment (S.Amdt. 742) that was adopted by the Senate. S.Amdt. 742 would allow for an advance appropriation for the medical services, medical administration, medical facilities, and medical and prosthetic research accounts of VHA and would not subject those accounts to a point of order under section 302 of S.Con.Res. 13. Sections 402 and 424 of the conference report on the FY2010 Concurrent Resolution on the budget (H.Rept. 111-60) have included language excepting the following accounts from point of order against advance appropriations: medical services, medical support and compliance, and medical facilities.⁴² Therefore, while the use of points of order may no longer apply to these accounts in the FY2010 Concurrent Budget Resolution (H.Rept. 111-60), future budget resolutions may need to include language excepting these accounts.

Implementation Issues

One concern for Congress would be the effects or impact of funding some accounts under an AA based on the estimates generated by the EHCPM. It has been acknowledged that “[VHA’s] formulation of its budget is by its very nature challenging, as it is based on assumptions and imperfect information on the health care services [VHA] expects to provide.”⁴³ As stated

⁴⁰ H.Con.Res. 85; U.S. Congress, House Committee on the Budget, *Concurrent Resolution on the Budget for Fiscal Year 2010*, 111th Cong., 1st sess., March 27, 2009, H.Rept. 111-60. The committee report has listed the following accounts for advance appropriations for FY2011: Employment and Training Administration; Office of Job Corps; Education for the Disadvantaged; School Improvement Programs; Special Education; Career, Technical and Adult Education; Payment to Postal Service; Tenant- based Rental Assistance; Project-based Rental Assistance.

⁴¹ U.S. Congress, Senate Committee on the Budget, *Concurrent Resolution on the Budget FY2010*, committee print, 111th Cong., 1st sess., S. Print 111-6 (Washington: GPO, 2009), p. 33.

⁴² “Conference Report on S.Con.Res 13, Concurrent Resolution on the Budget for Fiscal Year 2010,” *Congressional Record*, daily edition, vol. 155 (April 27, 2009), p. H4817.

⁴³ U.S. Government Accountability Office, *VA Health Care Challenges in Budget Formulation and Execution*, GAO- (continued...)

previously, the EHCPM provides the basis for estimating VHA's budget request to Congress. While the EHCPM reasonably projects future enrollment estimates and is "likely to yield accurate projections in a stable policy environment," it has also been found that "the current specification of the EHCPM appears to lack the specificity to inform explicit scenarios regarding the relationships among VA benefit generosity, other sources of health coverage, veterans' enrollment decisions, and enrollee health status"⁴⁴ Under such findings it is reasonable to assume that future year budget projections could have variances that could create budget shortfalls if there are unanticipated shocks to the VA health care system or to the surrounding policy environment. For instance, if under the current economic climate large numbers of veterans lose their employer provided health insurance coverage, and for the first time try to seek care from the VA health care system, the EHCPM may not be able to accurately forecast such a scenario. Furthermore, the recent RAND study on the EHCPM expressed concerns regarding the validity and accuracy of the current approach for projecting future expenditures under budget and policy scenarios beyond the VA's current capacity to provide care.⁴⁵

While expenditures for medical services modeled through the EHCPM comprise about 84% of VHA's budget estimate to Congress, some programs such as long-term care are estimated separately by VHA and included in its budget estimates to Congress. The Government Accountability Office (GAO) has expressed concern with VHA's long-term care spending estimates because the estimates are based on cost assumptions that GAO believes to be unrealistically low and on a noninstitutional workload projection that appears to be unrealistically high.⁴⁶ Furthermore, it has stated that "VA's long-term care spending estimates are questionable benchmarks for congressional budget deliberations."⁴⁷ Given these concerns it is reasonable to consider whether funding VHA under AA could still create potential budget shortfalls, which Congress would have to address through a regular appropriations bill.

Another issue that may arise would be how funding for VHA information technology programs including its electronic medical records system (Veterans Health Information Systems and Technology Architecture (VistA)) relate to funding the rest of the VHA under an AA. In October 2005, the VA began to reorganize its information technology (IT) functions to improve the management of its IT programs.⁴⁸ Before the realignment, funding and approval of IT functions were controlled by each medical center director.⁴⁹ The reorganization consolidated all IT functions throughout the VA under control of the VA Chief Information Officer (CIO). As a result of this reorganization, VHA's health IT budget was brought under central control. Currently, all IT programs within the VA are funded under the Information Technology account. Furthermore, to support health care, VA IT infrastructure provides VA facilities with voice services and data

(...continued)

09-459T, March 12, 2009, p. 1.

⁴⁴ Footnote 28, p.46.

⁴⁵ Footnote 28, p.75.

⁴⁶ U.S. Government Accountability Office, *VA Health Care: Long-Term Care Strategic Planning and Budgeting Need Improvement*, GAO-09-145, January 2009, p. 29.

⁴⁷ Ibid.

⁴⁸ U.S. Government Accountability Office, *Information Technology: VA Has Taken Important Steps to Centralize Control of Its Resources, but Effectiveness Depends on Additional Planned Actions*, GAO-08-449T, February 13, 2008, p. 4.

⁴⁹ U.S. Government Accountability Office, *Veterans Affairs: Health Information System Modernization Far from Complete; Improved Project Planning and Oversight Needed*, GAO-08-805, June 30, 2008, p. 9.

capture, processing, transmission, and analysis. Health care professionals maintain and transmit patient data and x-ray, MRI, and other images to serve veterans wherever service is required. In addition, VA is undertaking the migration of VistA into VA's new health care system, HealtheVet. Due to all these reasons, providing an AA for three accounts and funding IT accounts under a regular appropriation act could create a situation whereby, for example, VHA could not purchase computer software although it has procured medical equipment that needs software, or may not be able to transmit patient data through VA's IT infrastructure. Likewise, when VHA expands new services, based on funding in the medical services account, there is frequently an IT component that would need funding from the VA's IT budget. If Congress funds some accounts under an AA, and the IT budget under a regular appropriation then, for example, when a new community-based outpatient clinic (CBOC) is opened, the IT infrastructure that is needed to support the clinic may not be available.

Another potential issue that may arise is VHA's ability to implement congressionally mandated policy changes. For instance, if Congress were to pass legislation to increase access to veterans in highly rural areas during FY2011, an advance appropriation might not be able to account for this legislative mandate, since funding for the medical services account would have already been appropriated for FY2011 during the FY2010 budget cycle.

Although it may be not be as significant as the previous three implementation issues—since medical and prosthetic research account funds are available to VHA for a period of two years—funding some accounts of VHA under an AA and some accounts under a regular FY appropriation could potentially create accounting complexities for VA's medical research programs. Under the current legislative proposal (H.R. 1016; S. 423), the following three accounts that comprise VHA would be funded under an AA: medical services, medical support and compliance, and medical facilities. Under this proposal the medical and prosthetic research account which funds VHA's research program would be excluded from being funded under an AA and would be funded under a regular FY appropriations act. This potentially could raise an issue with regard to timing of funding research projects and funding research support (personnel costs, administrative support, among other things). Under the current appropriations account set-up, research support from the medical care budget (distributed through the Veterans Equitable Resource Allocation (VERA) process⁵⁰) includes one year funding for personal services costs for individuals on the medical care rolls who spend a portion of their VA time working on research projects, and includes administrative support provided to the research program by fiscal, engineering, acquisition and materiel management units of the VA. As stated before, this could potentially create a mismatch between funding research projects and funding research support.

Other Options for Congress

There are some options that might help Congress in deciding on the long-term financing of VA health care. One option would be for Congress to provide oversight and direction to VHA to modify its EHCPM so that it could provide better predictability for VHA funding in future years. VHA would have to develop analytic tools for measuring demand for health care, treatment capacity, and the fixed and variable costs associated with delivering care. Furthermore, forecasting the effects of VA policy and external influences on demand requires routine collection

⁵⁰ Congressionally appropriated medical care funds are allocated to the VHA networks based on the Veterans Equitable Resource Allocation (VERA) system, which generally bases funding on patient workload.

of data on veterans' employment, health insurance, health status, and overall health care utilization. These modifications could provide VHA and Congress with better estimates of funding needs, and thereby allow Congress to make informed policy decisions.

Another option might be to create an independent entity modeled along the lines of the Medicare Payment Advisory Commission (MedPAC). Creation of such an entity could bring transparency to VHA's funding process and would create credibility, particularly among key constituent groups. MedPAC was established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise Congress on issues affecting the Medicare program. The Commission's statutory mandate includes advising Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program. Furthermore, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare. The Commission meets publicly to discuss Medicare issues and policy questions and to develop and approve its reports and recommendations to the Congress. Such a program for VHA might independently analyze issues facing VHA and advise Congress on funding for both short-and long-term issues affecting health care for veterans.⁵¹ This could in turn provide an added layer of transparency and accountability to VHA's budget process.

⁵¹ Medicare Payment Advisory Commission, *Report to the Congress, Medicare Payment Policy*, March 2008, [www.medpac.gov].

Appendix. Department of Veterans Affairs (VA) Appropriation Acts, FY1989-FY2009

Fiscal Year	Law Title	Date of Enactment	Public Law Number and Bill Number
1989	Department of Housing and Urban Development-Independent Agencies Appropriations Act, 1989	August 19, 1988	P.L. 100-404 [H.R. 4800]
1990	Departments of Veterans Affairs and Housing and Urban Development, Independent Agencies Appropriations Act, 1990	November 9, 1989	P.L. 101-144 [H.R. 2916]
1991	Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1991	November 5, 1990	P.L. 101-507 [H.R. 5158]
1992	Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1992	October 28, 1991	P.L. 102-139 [H.R. 2519]
1993	Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1993	October 6, 1992	P.L. 102-389 [H.R. 5679]
1994	Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1994	October 28, 1993	P.L. 103-124 [H.R. 2491]
1995	Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1995	September 28, 1994	P.L. 103-327 [H.R. 4624]
1996	Omnibus Consolidated Rescissions and Appropriations Act of 1996	April 26, 1996	P.L. 104-134 [H.R. 3019]
1997	Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997	September 26, 1996	P.L. 104-204 [H.R. 3666]
1998	Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1998	October 27, 1997	P.L. 105-65 [H.R. 2158]
1999	Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1999	October 21, 1998	P.L. 105-276 [H.R. 4194]
2000	Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2000	October 20, 1999	P.L. 106-74 [H.R. 2684]

Fiscal Year	Law Title	Date of Enactment	Public Law Number and Bill Number
2001	Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2001	October 27, 2000	P.L. 106-377 [H.R. 4635]
2002	Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 2002	November 26, 2001	P.L. 107-73 [H.R. 2620]
2003	Consolidated Appropriations Resolution, 2003	February 20, 2003	P.L. 108-7 [H.J. Res. 2]
2004	Consolidated Appropriations Act, 2004	January 23, 2004	P.L. 108-199 [H.R. 2673]
2005	Consolidated Appropriations Act, 2005	December 8, 2004	P.L. 108-447 [H.R. 4818]
2006	Military Quality of Life and Veterans Affairs Appropriations Act, 2006	November 30, 2005	P.L. 109-114 [H.R. 2528]
2007	Revised Consolidated Appropriations Resolution, 2007	February 15, 2007	P.L. 110-5 [H.J. Res. 20]
2008	Consolidated Appropriations Act, 2008	December 26, 2007	P.L. 110-161 [H.R. 2764]
2009	Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009	September 30, 2008	P.L. 110-329 [H.R. 2638]

Source: Table prepared by the Congressional Research Service.

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Acknowledgments

The author wishes to thank Dr. Katherine Harris, for individually briefing the author on the RAND study that evaluated the Enrollee Health Care Projection Model (EHCPM), and providing him with a greater understanding of a very complicated model.